REQUEST FOR MEDICAL EXEMPTION FROM COVID-19 VACCINATION

Dear Physician:

The University of Baltimore (UBalt), as mandated by the University System of Maryland, requires COVID-19 vaccinations for all students, faculty, and staff. A medical exemption from COVID-19 vaccination is allowed for certain recognized contraindications (https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html).

Please complete the form below. Should you have any questions, please contact smogar@ubalt.edu Thank you.

The above person should not be immunized for COVID-19 for the following reasons (Please check all that apply):

☐ Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine

☐ Immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine (Vaccine Ingredients: https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#Appendix-C)

Which ingredient caused an allergic reaction? _____

What was the reaction? _____

Which brand of the COVID-19 vaccine is contraindicated and why? _____

_____

_____

How long will the medical contraindication last? _____

☐ Other Medical Reason – Please provide this information in a separate narrative (see pg. 3 for additional space) that describes the other medical reason justifying an exemption in detail.

FOR THE PHYSICIAN

I certify that _____ has the above contraindication or specific medical condition and request a medical exemption from COVID-19 vaccination.

Physician Signature: _____ Date: _____
(Note: Signature Stamp Not Acceptable)

Physician Medical License No.: _____ NPI No.: _____

FOR THE REQUESTOR (Student/Faculty/Staff)

Verification and Accuracy:

I verify that the above information is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action which may include termination/dismissal (faculty/staff) and suspension/expulsion (students). I also understand that my request for an exemption may not be granted if it creates an undue hardship for the University.

Signature: _____ Date: _____

Print Name: _____

UBalt ID No.:_____

Signature of Parent or Guardian (if <18 years old) _____

Print Name: _____ Date: _____

Confidentiality of Information Provided

Requests for exemptions and any documents provided will be kept confidential and shared only with those university employees who have a need to know.

UBALT DESIGNATED OFFICE USE ONLY:

Medical Exemption Approved Date: _____

Approving Staff Signature:_____

Name/ Title: _____

Additional Space for Medical Explanation: